STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495194	A. BUILDING _____ B. WING _____	C 07/15/2015

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AUTUMN CARE OF PORTSMOUTH	3610 WINCHESTER DR PORTSMOUTH, VA 23707

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare special focus survey was conducted 7/14/15 through 7/15/15. Corrections are required for compliance with the following Federal Long Term Care requirements.

The census in this 108 certified bed facility was 96 at the time of the survey. The survey sample consisted of 10 current resident reviews (Residents #1 through #10).

RECEIVED
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F 278 SS=E — 483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED

The assessment must accurately reflect the resident's status.

A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

A registered nurse must sign and certify that the assessment is completed.

Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

F 278

Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions written in the statement of deficiencies. This plan of correction is prepared soley because of the requirements under state and federal law.

1. *Address how correction action will be accomplished for those residents found to have been affected by the deficient practice.*

Residents # 3 # 4 # 6 and # 9 assessments were reviewed immediately and modification procedures will be implemented to correct completed MDS assessments . Clinical corrections will also be undertaken as necessary to assure that all residents are accurrately asssesed, care plan is accurate and all residents are recieveing necessary care.

MDS corrections have been completed and transmitted as follows: for
resident #3 (foley catheter and urinary tract infection),
resident #4 (section I,active diagnosis related to the fracture),
resident #6(entry assessment),
resident #9 (BPH and obstructive uropathy).

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Anette Allen-Santos	Administratr	8/6/15

any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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Clinical disagreement does not constitute a material and false statement.

This REQUIREMENT is not met as evidenced by:
Based on resident interview, staff interview and clinical record review it was determined that the facility staff failed to ensure a complete and accurate Minimum Date Set (MDS) assessment for 4 of 10 Residents in the sample survey. Resident #3, Resident #4, Resident #6 and Resident #9.
The Findings Included.
1. For Resident #3 the facility staff failed to ensure a complete and accurate Annual Minimum Data Set (MDS) assessment with the Assessment Reference Date (ARD) of 3/27/15. The facility staff failed to code that Resident #3 had a Foley catheter. The facility staff also incorrectly coded that Resident #3 had a urinary tract infection.
Resident #3 was a 76 year old female who was admitted on 5/13/10. Admitting diagnoses included, but were not limited to: anxiety, depression, urinary tract infection, hypertension, diabetes mellitus, psychosis and a cerebrovascular accident with aphasia.
The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS with an Assessment Reference Date (ARD) of 6/25/15. The facility staff coded that Resident #3 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #3 required extensive assistance (3/2) with Activities of Daily Living (ADL's). The facility staff also coded that Resident #3 was totally incontinent of bladder and bowel (3/3).
On July 15, 2015 at 9:50 a.m. the surveyor

2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice

All residents have the portential to be affected.
A 100% MDS assessment audit on residents with foley catheters was conducted since 7/16/2015 and is ongoing.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

MDS coordinators will be educated by the Corporate Q/A nurse regarding accurately coding to include but not limited to
-Section H
-Diagnosis codes
-Criteria for coding UTI's
-Review of assessments
The staff development coordinator will inservice the licensed nursing staff on the s/s of UTI, including the necessary criteria for documentation.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The DON or designee will audit 50% of MDS assessments completed weekly for the above issues x 4 months and subsequently on a random basis of at least 1 per week until consistent compliance is met for a minimum of three months.
Quality assurance nurse will review MDS assessments on all residents with foley catheters. Audit results will be shared in weekly standards of care and Q/A meetings.

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F 278	Continued From page 2 reviewed Resident #3's clinical record. Review of the clinical record produced a Nurse Practitioner (NP) note dated 2/12/15 that read in part . . "MASD (maceration associated skin damage) - place foley cath (catheter) prevention of skin breakdown pressure ulcer infection continue with calmoseptine for barrier urinary incontinence-high risk UTI's (urinary tract infections) skin breakdown." (sic) Continued review of the clinical record produced a physician order dated 2/12/15. The order read ... "Foley catheter once for 1 days Schedule Note: insert foley cath-prevent skin breakdown ® unresolved MASD risk for infection." (sic) The Foley catheter was discontinued on 3/24/15. Further review of the clinical record produced a NP note dated 3/24/15 that read in part ... "wants the catheter gone .. urinary management-D/C (discontinue) foley- v (check) UA+CS (urinalysis and culture and sensitivity) with D/C." (sic) Continued review of the clinical record produced Resident #3's vital signs and Nursing Progress Notes for the time frame of 3/1/15 though 3/31/15. The vital sign records and Nursing Progress Notes failed to document any associated signs or symptoms of a UTI. The Nursing Progress Notes documented that the UA and C&S was obtained on 3/24/15 and that Foley catheter was also discontinued on 3/24/15. Further review of the clinical record produced the results of a U/A and C&S dated 3/27/15 that documented that the urinalysis showed 2+ blood, 3+ leucocytes, white blood cells to numerous to count. The C&S showed that the urine culture was susceptible to numerous antibiotics. The facility staff faxed/notified the physician of the results of the UA and C&S. The physician ordered Cipro 500mg by mouth every 12 hours for 7 days.	F 278	*5. Include dates when corrective action will be completed. All corrective action shall be completed on or before 8/28/2015*	

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Additional review of the clinical record produced an Annual MDS assessment with an ARD of 3/27/15. The facility staff coded that Resident #3 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #3 required extensive assistance (3/2) with ADL's. In Section H. Bowel and Bladder the facility staff coded that Resident #3 was incontinent of bladder and bowel. The facility staff did not code that Resident #3 had an indwelling Foley catheter within the look back period of seven (7) days. In Section I. Active Diagnoses 12300. Urinary Tract Infection (UTI) (Last 30 Days) the facility staff coded that Resident #3 had a UTI in the past 30 days.

On July 15, 2015 at 10:15 a.m. the surveyor notified the Director of Nursing (DON) and the MDS Nurse (who was a Licensed Practical Nurse (LPN)) that Resident #3 had a Foley catheter inserted on 2/12/15. The surveyor notified the DON and MDS Nurse that the Foley was discontinued on 3/24/15. The surveyor notified the DON and MDS Nurse that Resident #3 had an Annual MDS assessment with the ARD of 3/27/15. The surveyor notified the DON and MDS Nurse that the look back period for Section H. Bladder and Bowel was seven (7) days and the MDS should have captured/coded the indwelling Foley catheter. The surveyor also notified the DON and MDS Nurse that four criteria had to be met to code/capture a UTI on the MDS. The surveyor notified the DON and MDS Nurse that the four criteria were signs and symptoms of a UTI, positive lab results, physician diagnoses and treatment. The surveyor notified the DON and the MDS Nurse that review of the clinical record failed to produce documentation of any signs or symptoms related to a UTI. The surveyor reviewed the clinical record with the

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DON and MDS Nurse. The surveyor pointed out the Foley catheter order and discontinuation of the Foley on 3/24/15. The surveyor also reviewed the NP note dated 3/24/15, UA and C&S results and physician order for Cipro. The DON and MDS Nurse were unable to locate documentation of signs and symptoms of a UTI. The surveyor notified the DON and MDS Nurse that the MDS should not have been coded for a UTI in the past 30 days as documented signs and symptoms of a UTI were not documented in the clinical record.

On July 15, 2015 at 5 p.m. the survey team met with the Administrative Team (AT) that consisted of the Administrator, DON, two MDS Nurses (whom were both LPN ' s), the Corporate Quality Assurance Nurse, the facility Quality Assurance Nurse, the Dietary Manager, the Staff Development Nurse (who was a LPN), the evening supervisor (who was a Registered Nurse (RN)), the Activities Director, the Business Office Manager and the weekend Supervisor (who was a RN). The surveyor notified the AT that Resident #3 had a Foley catheter inserted on 2/12/15 for MASD. The surveyor notified the AT that the Foley was discontinued on 3/24/15. The surveyor notified the AT that the Annual MDS with the ARD of 3/27/15 failed to capture the use of an indwelling Foley catheter. The surveyor notified the AT that the look back period for Section H. Bladder and Bowel was 7 days and the use of the indwelling Foley catheter should have been captured/coded on the MDS. The surveyor also notified the AT that the facility staff inaccurately coded Resident #3 as having a UTI in the past 30 days on the Annual MDS assessment. The surveyor notified the AT that signs and symptoms of a UTI were not documented in the clinical record; therefore, a UTI could not be

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captured/coded on the MDS.
No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate MDS assessment for Resident #3.

2. For Resident #4 the facility staff failed to ensure that two Minimum Data Set (MDS) assessments were accurate. The MDS assessments had the Assessment Reference Date (ARD's) of 6/26/15 and 7/3/15. The facility staff failed to code Section I. Active Diagnoses Musculoskeletal I4000. Other fracture.
Resident #4 was an 89 year old female who was originally admitted on 4/22/13 and readmitted on 6/20/15. Admitting diagnoses included, but were not limited to: fall, insomnia, dementia with behaviors, hypertension, rheumatoid arthritis and a fractured right femur.
The most current MDS located in the clinical record was a 14 Day Medicare MDS assessment with the ARD of 7/3/15. The facility staff coded that Resident #4 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #4 required extensive assistance (3/2) with Activities of Daily Living (ADL's). In Section I. Active Diagnoses the facility staff did not code in 14000 that Resident #4 had an "Other Fracture."
On July 15, 2015 at 8 a.m. the surveyor observed Resident #4 lying in bed. The surveyor interviewed Resident #4 regarding her staff at the facility and her recent fall. Resident #4 informed the surveyor that a few weeks ago she had gotten up without assistance and had fell and broke her leg.
On July 15, 2015 at 11:20 a.m. the surveyor reviewed Resident #4's clinical record. Review of the clinical record produced "Progress Notes" dated 6/16/15 that documented that Resident #4 was found in the floor at the side of her bed.

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Resident #4 complained that her leg hurt and stated ... "don't move my leg ... my thigh hurts." Resident #4 was sent to the hospital emergency room for evaluation.

Further review of the clinical record produced a "History and Physical" and a "Physician Order Sheet." These two documents documented that Resident #4 had a right femur fracture.

Continued review of the clinical record produced a Medicare 5 Day MDS assessment with an ARD of 6/26/15. The facility staff coded that Resident #4 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #4 required extensive assistance (3/2) with Activities of Daily Living (ADL's). In Section I. Active Diagnoses the facility staff did not code in 14000 that Resident #4 had an "Other Fracture."

On July 15, 2015 at 11:25 a.m. the surveyor notified the MDS Nurse that the facility staff failed to capture/code Resident #4's right femur fracture on the MDS's with the ARD's of 6/26/15 and 7/3/15. The surveyor reviewed Resident #4's clinical record to include the 2 MDS's with the MDS Nurse. The surveyor pointed out that In Section I. Active Diagnoses was not code in 14000 that Resident #4 had an "Other Fracture." The surveyor notified the MDS Nurse that "I4000 Other Fracture" should have been coded.

On July 15, 2015 at 5 p.m. the survey team met with the Administrative Team (AT) that consisted of the Administrator, Director of Nurses (DON), two MDS Nurses (whom were both LPN's), the Corporate Quality Assurance Nurse, the facility Quality Assurance Nurse, the Dietary Manager, the Staff Development Nurse (who was a LPN), the evening supervisor (who was a Registered Nurse (RN)), the Activities Director, the Business Office Manager and the weekend Supervisor (who was a RN). The surveyor notified the AT

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that Resident #4 had a right femur fracture on 6/16/15 due to a fall at the side of her bed. The surveyor notified the AT that the facility staff had not coded Section I. Active Diagnoses I4000 for "Other Fracture" on a 5 Day Medicare MDS assessment with the ARD of 6/26/15 and a 14 Day Medicare MDS assessment with the ARD of 7/3/15. The surveyor notified the AT that the facility staff failed to ensure a complete and accurate MDS assessment for Resident #4. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate MDS's for Resident #4.

3. For Resident #6, facility staff failed to complete an entry MDS assessment after a resident re-entered the facility after a hospital admission.

Resident #6 was admitted to the facility on 6/17/03 and readmitted to the facility on 5/22/15. Diagnoses included urinary tract infection, malnutrition, dementia, and depression. The resident was assessed with long and short term memory deficits and impaired cognitive skills for daily decision making.

During clinical record review on 7/15/15, the surveyor noted that the most recent MDS assessment was for Discharge, Return Anticipated on 5/18/15. No subsequent MDS assessment had been completed.

The director of nursing and MDS coordinator were notified of the concern on 7/15/15.

4. For Resident #9, facility staff failed to maintain accurate diagnosis lists on MDS assessments.

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Resident #9 was admitted to the facility on 4/2/15 with diagnoses including HTN, UTI, arthritis, traumatic brain injury, and muscle weakness. The resident scored 15/15 on the Brief Interview for Mental Status and was assessed with no signs of delirium or psychosis.

During clinical record review, the surveyor reviewed the admission MDS assessment with ARD 4/9/15. The resident was assessed with an indwelling catheter. The active diagnoses list included Section I 1400 benign prostatic hyperplasia(BPH) and I 1650 urinary obstruction was not checked. Section I 18000 (additional diagnoses) listed urinary obstruction NOS, and BPH w/o obs/luts. The resident's care plan dated 4/12/15 listed urethral catheter related to diagnosis of obstructive uropathy causing inability to void and empty bladder; diagnosis: 600.00 BPH w/o urinary obs/luts.

The surveyor asked the director of nursing and MDS coordinator which diagnosis was correct and was given the Skilled Nursing Facility Transfer Report dated 3/22/15. The past medical history did not list prostatic hypertrophy. The assessment included diagnosis of obstructive uropathy. The MDS assessment did not reflect the physician's diagnosis.

The administrator, director of nursing, and MDS coordinator were informed of the concern on 7/15/15.

F 278

F 315 SS=E 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

F 315

Based on the resident's comprehensive

Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth

(cont. on next page.)

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assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review it was determined that the facility staff failed to anchor and indwelling Foley catheter and a Supra-pubic catheter for 2 of 10 Residents in the sample survey, Resident #2 and #1.
Additionally, the facility staff failed to provide medical justification for the use of a Foley catheter for 1 of 10 Residents in the sample survey, Resident #3.
1. For Resident #2 the facility staff failed to anchor an indwelling Foley catheter.
2. For Resident #3 the facility staff failed to provide medical justification for the use of a Foley catheter.
3. For Resident #1 the facility staff failed to anchor a Supra-pubic catheter.
The Findings Included:
1. For Resident #2 the facility staff failed to anchor an indwelling Foley catheter.
Resident #2 was a 76 year old male who was admitted on 7/24/14. Admitting diagnoses included, but were not limited to: dementia with behaviors, gastrostomy tube placement, urine retention, hypertension, urinary tract infection and bacterial pneumonia.

F 315

(continued from previous page)
of the facts alleged or the correctness of the conclusions written in the statement of deficiencies. This plan of correction is prepared soley because of the requirements under state and federal law.

1. Address how correction action will be accomplished for those residents found to have been affected by the deficient practice.
Resident # 2 and #1 had their foley catheters anchored immediately to maintain a safe environment.

Resident #3 had foley discontinued prior to the start of the survey

100% of all residents with an indwelling catheter and or those at risk as evidenced by NP assessments will be audited for medical justification. DON or designee will ensure a standards of care review for all.

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The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date of 4/11/15. The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and was moderately impaired with daily decision making regarding Activities of Daily Living (ADL's). The facility staff coded that Resident #2 required extensive assistance (3/2) with ADL's. In Section H. Bowel and Bladder the facility staff coded that Resident #2 had an indwelling urethral catheter.

On July 15, 2015 at 7:45 a.m. the surveyor observed Resident #2 lying in bed on his right side. The surveyor observed a Foley catheter tubing extending from the left hand side of the bed covers. The surveyor observed a Certified Nursing Assistant (C.N.A. #1) walking in the hallway. The surveyor asked for C.N.A. (#1) to step into Resident #2's room. The surveyor informed the C.N.A. (#1) that she wanted to see if Resident #2's catheter was anchored. The C.N.A. (#1) lifted Resident #2's bed covers. The surveyor and C.N.A. (#1) observed Resident #2 lying on his right side with his knees bend at 90 degrees. Resident #2's heels were almost touching his diaper in the buttocks area. The surveyor and C.N.A. (#1) observed that the Foley catheter was exiting the back of the diaper. No anchor was observed. The surveyor and C.N.A. (#1) also observed that the Foley catheter tubing and the urinary drainage bag tubing were completely encompassing Resident #2's left ankle.

On July 15, 2015 at 7:50 a.m. the surveyor notified the Unit Charge nurse, who was a Licensed Practical Nurse (LPN #2) that Resident #2's Foley catheter was not anchored and that the Foley catheter tubing and urinary drainage

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2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice
All residents have the portential to be affected.
A 100% assessment audit on residents with foley catheters was conducted since 7/16/2015 and is ongoing.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The staff development coordinator and or designee will in-service all certified and licensed nursing staff on the care and use of indwelling catheters. Inservices will include but not be limited to
a) acceptable diagnosis for indwelling catheter use.
b) catheter care and anchoring of the related tubing.

All residents with indwelling catheters will be reviewed at weekly standards of care meeting.

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bag tubing were completely encompassing Resident #2's left ankle. The surveyor asked LPN (#2) if Resident #2's Foley catheter was supposed to be anchored and LPN (#2) stated, "Yes."

On July 15, 2015 at 8:10 a.m. the surveyor notified the Director of Nursing (DON) that Resident #2's Foley catheter was not anchored and that the Foley catheter tubing and urinary drainage bag tubing were completely encompassing his left ankle. The surveyor requested a copy of the facility policy and procedure for catheter care.

On July 15, 2015 at 8:20 a.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Foley Catheter Every 14 days continuous Change Foley Catheter drainage bag q (every) 2 weeks DX (diagnoses) Foley catheter care. RETENTION OF URINE." (sic)

On July 15, 2015 at 5 p.m. the survey team met with the Administrative Team (AT) that consisted of the Administrator, DON, two MDS Nurses (whom were both LPN's), the Corporate Quality Assurance Nurse, the facility Quality Assurance Nurse, the Dietary Manager, the Staff Development Nurse (who was a LPN), the evening supervisor (who was a Registered Nurse (RN)), the Activities Director, the Business Office Manager and the weekend Supervisor (who was a RN). The surveyor notified the AT that Resident #2's Foley catheter was not anchored to prevent excessive tension of the urinary meatus. The surveyor also notified the AT that the Foley catheter tubing and urinary drainage bad tubing were completely encompassing Resident #2's left ankle.

On July 15, 2015 at 5:10 p.m. the DON hand

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The unit managers' or designees' daily rounding will include but not be limited to the following pertaining to indwelling catheters:

a)Catheter tubing is safely secured and appropriately anchored.

DON or designee will do a 100% audit of current residents with orders for indwelling catheters to ensure there is medical justification.

DON or designee will audit new orders for indwelling catheters for medical justification. The audit will be ongoing. All results will be shared in standards of care and quality assurance meetings.

5. Date when corrective action will be completed

All corrective action shall be completed on or before 8/28/2015

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delivered a document that had been copied from a book and was titled ... "374 (page) Indwelling Urinary Catheter Care and Removal." The document read in part ... "Tape catheter to the patient's abdomen or thigh to prevent pressure on the urethra at the penoscrotal junction, which can lead to formation of urethrocutaneous fistulas. Taping this was also prevents traction on the bladder and alteration in normal direction of urine flow in males. As an alternative, secure the catheter to the patient's thigh using a leg band with a Velcro closure. This method decreases skin irritation, especially in patients with long-term indwelling catheters."
No additional information was provided prior to exiting the facility as to why the facility staff failed to anchor Resident #2's indwelling Foley catheter.
2. For Resident #3 the facility staff failed to provide medical justification for the use of an indwelling Foley catheter.
Resident #3 was a 76 year old female who was admitted on 5/13/10. Admitting diagnoses included, but were not limited to: anxiety, depression, urinary tract infection, hypertension, diabetes mellitus, psychosis and a cerebrovascular accident with aphasia.
The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS with an Assessment Reference Date (ARD) of 6/25/15. The facility staff coded that Resident #3 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #3 required extensive assistance with Activities of Daily Living (ADL's). The facility staff also coded that Resident #3 was totally incontinent of bladder and bowel (3/3).
On July 15, 2015 at 9:50 a.m. the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced a Nurse Practitioner

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(NP) note dated 2/12/15 that read in part ... "MASD (maceration associated skin damage) - place foley cath (catheter) prevention of skin breakdown pressure ulcer infection continue with calmoseptine for barrier urinary incontinence-high risk UTI's (urinary tract infections) skin breakdown." (sic)

Maceration associated skin damage is the softening and breaking down of skin resulting from prolonged exposure to moisture.

Continued review of the clinical record produced a physician order dated 2/12/15. The order read ... "Foley catheter once for 1 days Schedule Note: insert foley cath-prevent skin breakdown ® unresolved MASD risk for infection." (sic) The Foley catheter was discontinued on 3/24/15.

Additional review of the clinical record failed to document that Resident #3 had a pressure ulcer or any medical justification for the use of the Foley catheter.

On July 15, 2015 at 10:15 a.m. the surveyor notified the Director of Nursing (DON) and the MDS Nurse (who was a Licensed Practical Nurse (LPN)) that Resident #3 had a Foley catheter inserted on 2/12/15. The surveyor notified the DON and MDS Nurse that a medical justification had not been documented for the use of the Foley catheter. The surveyor notified the DON and MDS Nurse that Resident #3's diagnoses for the use of the Foley catheter was maceration of the skin. The surveyor notified the DON and MDS Nurse that maceration was caused by incontinence and being wet for extended periods of time. The surveyor notified the DON and MDS Nurse that incontinence and maceration were not medically justified diagnoses for the use of a Foley catheter. The surveyor notified the DON and MDS Nurse that the facility staff should have kept Resident #3 clean and dry, implemented

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other interventions such as a toileting program rather than inserting a Foley catheter.
On July 15, 2015 at 5 p.m. the survey team met with the Administrative Team (AT) that consisted of the Administrator, DON, two MDS Nurses (whom were both LPN's), the Corporate Quality Assurance Nurse, the facility Quality Assurance Nurse, the Dietary Manager, the Staff Development Nurse (who was a LPN), the evening supervisor (who was a Registered Nurse (RN)), the Activities Director, the Business Office Manager and the weekend Supervisor (who was a RN). The surveyor notified the AT that Resident #3 had a Foley catheter inserted on 2/12/15 for MASD. The surveyor notified the AT that maceration was caused by incontinence and being left wet for extended periods of time. The surveyor notified the AT that incontinence was not an acceptable medical justification for the use of a Foley catheter.
No additional information was provided prior to exiting the facility as to why the facility staff failed to provide/obtain medical justification for the use of a Foley catheter for Resident #3.
3. For Resident #1, facility staff failed to anchor a suprapubic catheter.
Resident #1 was admitted to the facility 11/14/12 with diagnoses including HTN, aphasia, late effect hemiplegia, neurogenic bladder, and status post above the knee amputation. On the 4/16/15 quarterly MDS assessment, the resident scored 3/15 on the brief interview for mental status and was not assessed with signs of delirium or psychosis.
On 7/15/15 at approximately 8 AM, the surveyor asked CNA #1, who was caring for the resident if the resident's catheter was anchored. She lifted the covers and said that it was not. The surveyor asked the director of nursing if the catheter

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should be anchored. She said that it should be anchored.
Clinical record review reveled a physician order dated 8/28/13 for anchor catheter tubing and check placement q shift and prn.
On July 15, 2015 at 5:10 p.m. the DON hand delivered a document that had been copied from a book and was titled ... "374 (page) Indwelling Urinary Catheter Care and Removal." The document read in part ... "Tape catheter to the patient's abdomen or thigh to prevent pressure on the urethra at the penoscrotal junction, which can lead to formation of urethrocutaneous fistulas. Taping this was also prevents traction on the bladder and alteration in normal direction of urine flow in males."
The administrator and director of nursing were notified of the concern during a summary meeting on 7/15/15.

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F 323 SS=D 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, clinical record review and facility document review it was determined that the facility staff failed to ensure an environment free of accident hazards for 1 of 10 Residents in the sample survey, Resident #2.

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Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions written in the statement of deficiencies. This plan of correction is prepared soley because of the requirements under state and federal law.

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The Findings Included:

1. For Resident #2 the facility staff failed to ensure an environment of accident hazards. The facility staff failed to anchor an indwelling Foley catheter. The Foley catheter tubing and urinary drainage bag tubing were completely encompassing Resident #2's left ankle.
Resident #2 was a 76 year old male who was admitted on 7/24/14. Admitting diagnoses included, but were not limited to: dementia with behaviors, gastrostomy tube placement, urine retention, hypertension, urinary tract infection and bacterial pneumonia.
The most current Minimum Data Set (MDS) located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date of 4/11/15. The facility staff coded that Resident #2 had short and long term memory impairment (1/1) and was moderately impaired with daily decision making regarding Activities of Daily Living (ADL's). The facility staff coded that Resident #2 required extensive assistance (3/2) with ADL's. In Section H. Bowel and Bladder the facility staff coded that Resident #2 had an indwelling urethral catheter.
On July 15, 2015 at 7:45 a.m. the surveyor observed Resident #2 lying in bed on his right side. The surveyor observed a Foley catheter tubing extending from the left hand side of the bed covers. The surveyor observed a Certified Nursing Assistant (C.N.A. #1) walking in the hallway. The surveyor asked for C.N.A. (#1) to step into Resident #2's room. The surveyor informed the C.N.A. (#1) that she wanted to see if Resident #2's catheter was anchored. The C.N.A. (#1) lifted Resident #2's bed covers. The surveyor and C.N.A. (#1) observed Resident #2 lying on his right side with his knees bend at 90 degrees. Resident #2's heels were almost

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1. Address how correction action will be accomplished for those residents found to have been affected by the deficient practice.
Resident # 2 was made safe immediately by anchoring catheter and freeing it from encompasing his left ankle.

2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice
All residents have the portential to be affected.
A 100% safety assessment audit on residents with foley catheters was conducted since 7/16/2015 and is ongoing.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

All certified and licensed staff inservice was initiated on 7/23/2015. The staff development coordinator will complete inservices..

Topics will include but not be limited to the following:
a) Catheter care and anchoring of tubing .
b) Review of catheter tubing to ensure an accident and hazard free environment.
c) placement checks of legs knees and feet.

Ongoing review and audits will be shared at weekly standards of care and quality assurance meetings.

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touching his diaper in the buttocks area. The surveyor and C.N.A. (#1) observed that the Foley catheter was exiting the back of the diaper. No anchor was observed. The surveyor and C.N.A. (#1) also observed that the Foley catheter tubing and the urinary drainage bag tubing were completely encompassing Resident #2's left ankle.

On July 15, 2015 at 7:50 a.m. the surveyor notified the Unit Charge nurse, who was a Licensed Practical Nurse (LPN #2) that Resident #2's Foley catheter was not anchored and that the Foley catheter tubing and urinary drainage bag tubing were completely encompassing Resident #2's left ankle. The surveyor asked LPN (#2) if Resident #2's Foley catheter was supposed to be anchored and LPN (#2) stated, "Yes." The surveyor informed LPN (#2) that if Resident #2 had straightened out his legs it would have pulled out the Foley catheter with the bulb inflated.

On July 15, 2015 at 8:10 a.m. the surveyor notified the Director of Nursing (DON) that Resident #2's Foley catheter was not anchored and that the Foley catheter tubing and urinary drainage bag tubing were completely encompassing his left ankle. The surveyor requested a copy of the facility policy and procedure for catheter care.

On July 15, 2015 at 8:20 a.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Foley Catheter Every 14 days continuous Change Foley Catheter drainage bag q (every) 2 weeks DX (diagnoses) Folet catheter care. RETENTION OF URINE." (sic)

On July 15, 2015 at 5 p.m. the survey team met with the Administrative Team (AT) that consisted

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4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The unit managers' or designees' daily rounds will include resident positioning specific to indwelling catheter placement, physical and environmental safety of tubing. Review shall be ongoing. Reporting shall occur in the daily standup meetings, weekly standards of care and quality assurance reviews.

5. Date when corrective action will be completed
All corrective action shall be completed on or before 8/28/2015

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The facility must post the following information on a daily basis:
o Facility name.
o The current date.
o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
- Registered nurses.
- Licensed practical nurses or licensed vocational nurses (as defined under State law).
- Certified nurse aides.
o Resident census.

The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:
o Clear and readable format.
o In a prominent place readily accessible to residents and visitors.

The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

This REQUIREMENT is not met as evidenced by:
Based on observation and staff interview, facility staff failed to post the total number and actual hours worked by each category of licensed and unlicensed nursing staff directly responsible for resident care per shift.

Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions written in the statement of deficiencies. This plan of correction is prepared soley because of the requirements under state and federal law.

1. Address how correction action will be accomplished for those residents found to have been affected by the deficient practice.

The facility posted the daily schedule of nursing staff in a prominent place readily accesible to residents and visitors on 7/16/2015

2.Address how the facility will identify other residents having the potential to be affected by the same deficient practice

All residents have the potential to be affected.

3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.

The DON and or designee will ensure the daily posting of the nursing staffing data for each shift.

4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.

The area of posting for the schedules will be monitored by the DON or designee on a daily basis. Monitoring shall be ongoing.

5. Date when corrective action will be completed
All corrective action shall be completed on or before 8/28/2015

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of the Administrator, DON, two MDS Nurses (whom were both LPN's), the Corporate Quality Assurance Nurse, the facility Quality Assurance Nurse, the Dietary Manager, the Staff Development Nurse (who was a LPN), the evening supervisor (who was a Registered Nurse (RN)), the Activities Director, the Business Office Manager and the weekend Supervisor (who was a RN). The surveyor notified the AT that Resident #2's Foley catheter was not anchored to prevent excessive tension of the urinary meatus. The surveyor also notified the AT that the Foley catheter tubing and urinary drainage bad tubing were completely encompassing Resident #2's left ankle and if he had straightened out his legs it would have pulled the Foley catheter out with the bulb still being inflated.

On July 15, 2015 at 5:10 p.m. the DON hand delivered a document that had been copied from a book and was titled ... "374 (page) Indwelling Urinary Catheter Care and Removal." The document read in part ... "Tape catheter to the patient's abdomen or thigh to prevent pressure on the urethra at the penoscrotal junction, which can lead to formation of urethrocutaneous fistulas. Taping this was also prevents traction on the bladder and alteration in normal direction of urine flow in males. As an alternative, secure the catheter to the patient's thigh using a leg band with a Velcro closure. This method decreases skin irritation, especially in patients with long-term indwelling catheters."

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure an environment free of accident hazards.

F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION	F 356	

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On entering the facility on 7/14/15, the surveyor was unable to locate staffing posting. The surveyor asked at the nurse's station where the nurse staffing totals were posted. Staff offered a folder containing "Autumn Care Daily Nursing Schedule" which was on a counter behind the nurse's station. The surveyor asked where the staffing was posted so that visitors would know how many nurses and aids worked that day and how many hours they worked. Staff said they didn't think they did that.

On 7/14, the administrator and director of nursing confirmed that the information was not posted. The administrator was able to provide the hours worked information from the payroll system. Both acknowledged there was no process for posting required nurse staffing information.